MSFC REQUEST FOR LEAVE WITHOUT PAY

PART I - EMPLOYEE INFORMATION

EMPLOYEE'S NAME:	ORG. SYMBOL:	WORK PHONE:

SOCIAL SECURITY NUMBER:	POSITION TITLE/GRADE:

PART II - REQUEST FOR LEAVE WITHOUT PAY (LWOP)

Complete this ONLY if you wish to request administrative approval of Leave Without Pay for more than 30 consecutive days. MSFC Policy is that LWOP over 30 days is approved in increments of no more than 90 days at a time. THIS REQUEST MUST BE ROUTED THROUGH YOUR ADMINISTRATIVE OFFICER. If this request for LWOP is for medical reasons, attach to this form a signed, original, doctor's statement (on doctor's letterhead) with a diagnosis and an approximate ending date of the medical emergency.

NUMBER OF DAYS BEING REQUESTED:	BEGINNING DATE (Month/Day/Year):	ENDING DATE (Month/Day/Year):

JUSTIFICATION:

I certify that I will return to my position at MSFC at the end of the approved period.

EMPLOYEE'S SIGNATURE: _____ DATE: _____

In accordance with MGM 3600.1, Ch2, 13.3, and after consultation with the employee, it has been determined that there is a reasonable expectation that the employee will return at the end of the approved LWOP period. Approval of this request will benefit NASA/MSFC by (check all items that apply):

☐ Increasing the job ability of the employee

☐ Ensuring retention of a very desirable employee

☐ Protecting or improving employee's health

☐ Furthering of a program of interest to the Government

CONCURRENCE		APPROVAL/DISAPPROVAL
FIRST LEVEL SUPERVISOR'S SIGNATURE:	DATE:	☐ APPROVED ☐ DISAPPROVED
SECOND LEVEL SUPERVISOR'S SIGNATURE:	DATE:	MANAGER, EMPLOYEE SERVICES AND OPERATIONS OFFICE SIGNATURE / DATE:

NOTICE: TO ARRANGE FOR PAYMENT OF HEALTH INSURANCE PREMIUMS DURING THIS PERIOD OF LEAVE WITHOUT PAY, CONTACT THE MSFC HUMAN RESOURCES OFFICE, MAIL CODE: HS50, PHONE: 544-7536.